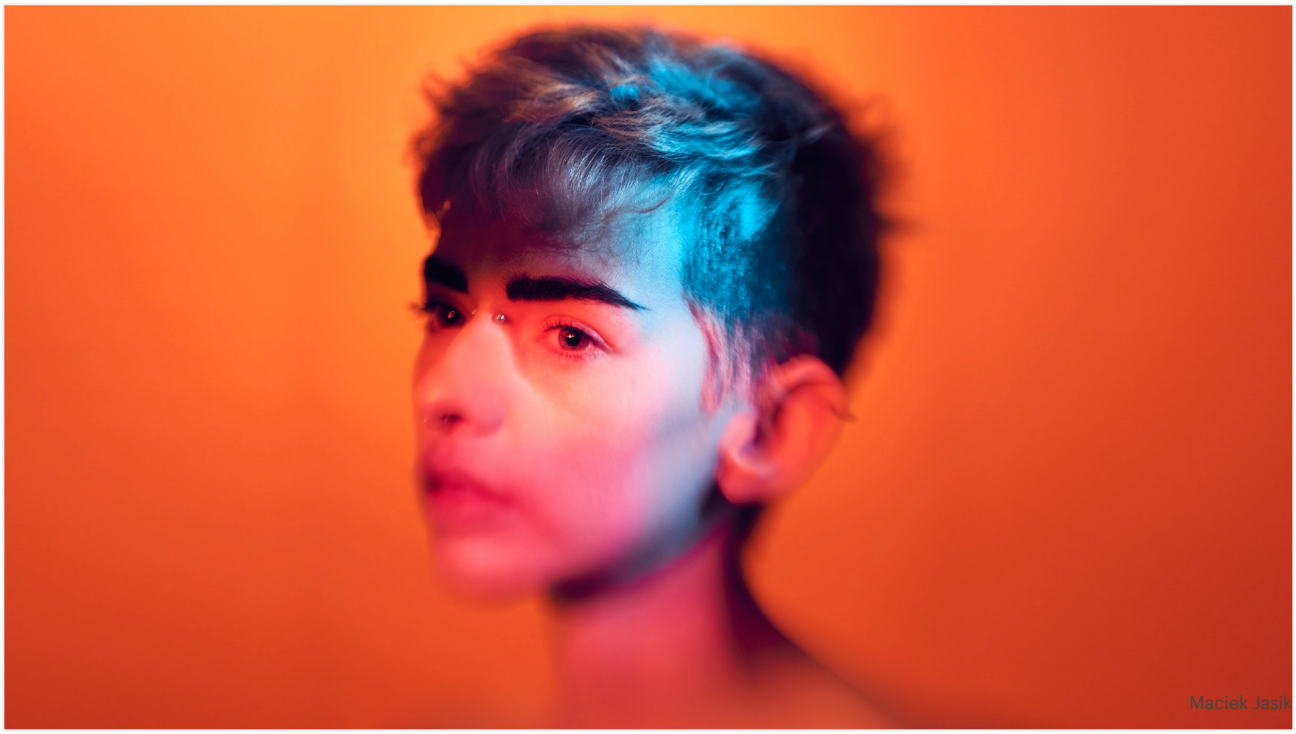
EXHIBIT A

The Atlantic

When Children Say They're Trans

Hormones? Surgery? The choices are fraught—and there are no easy answers.



Story by Jesse Singal

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Claire is a 14-year-old girl with short auburn hair and a broad smile. She lives outside Philadelphia with her mother and father, both professional scientists. Claire can come across as an introvert, but she quickly opens up,

and what seemed like shyness reveals itself to be quiet self-assuredness. Like many kids her age, she is a bit overscheduled. During the course of the evening I spent with Claire and her mother, Heather—these aren't their real names—theater, guitar, and track tryouts all came up. We also discussed the fact that, until recently, she wasn't certain she was a girl.

Sixth grade had been difficult for her. She'd struggled to make friends and experienced both anxiety and depression. "I didn't have any self-confidence at all," she told me. "I thought there was something wrong with me." Claire, who was 12 at the time, also felt uncomfortable in her body in a way she couldn't quite describe. She acknowledged that part of it had to do with puberty, but she felt it was more than the usual preteen woes. "At first, I started eating less," she said, "but that didn't really help."

Around this time, Claire started watching YouTube videos made by transgender young people. She was particularly fascinated by MilesChronicles, the channel of Miles McKenna, a charismatic 22-year-old. His 1 million subscribers have followed along as he came out as a trans boy, went on testosterone, got a double mastectomy, and transformed into a happy, healthy young man. Claire had discovered the videos by accident, or rather by algorithm: They'd showed up in her "recommended" stream. They gave a name to Claire's discomfort. She began to wonder whether she was transgender, meaning her internal gender identity didn't match the sex she had been assigned at birth. "*Maybe the reason I'm uncomfortable with my body is I'm supposed to be a guy*," she thought at the time.

Claire found in MilesChronicles and similar YouTube videos a clear solution to her unhappiness. "I just wanted to stop feeling bad, so I was like, *I should just transition*," she said. In Claire's case, the first step would be gaining access to drugs that would halt puberty; next, she would start taking testosterone to develop male secondary sex characteristics. "I thought that that was what made you feel better," she told me.

In Claire's mind, the plan was concrete, though neither Heather nor her husband, Mike, knew about any of it. Claire initially kept her feelings from her parents, researching steps she could take toward transitioning that wouldn't require medical interventions, or her parents' approval. She looked into ways to make her voice sound deeper and into binders to hide her breasts. But one day in August 2016, Mike asked her why she'd seemed so sad lately. She explained to him that she thought she was a boy.

This began what Heather recalls as a complicated time in her and her husband's relationship with their daughter. They told Claire that they loved and supported her; they thanked her for telling them what she was feeling. But they stopped short of encouraging her to transition. "We let her completely explore this on her own," Heather told me.

To Claire's parents, her anguish seemed to come out of nowhere. Her childhood had been free of gender dysphoria—the clinical term for experiencing a powerful sense of disconnection from your assigned sex. They were concerned that what their daughter had self-diagnosed as dysphoria was simply the travails of puberty.

As Claire passed into her teen years, she continued to struggle with mental-health problems. Her parents found her a therapist, and while that therapist worked on Claire's depression and anxiety—she was waking up several times a night to make sure her alarm clock was set correctly—she didn't feel qualified to help her patient with gender dysphoria. The therapist referred the family to some nearby gender-identity clinics that offered transition services for young people.

Claire's parents were wary of starting that process. Heather, who has a doctorate in pharmacology, had begun researching youth gender dysphoria for herself. She hoped to better understand why Claire was feeling this way and what she and Mike could do to help. Heather concluded that Claire met the clinical criteria for gender dysphoria in the *DSM-5*, the American Psychiatric Association's diagnostic manual. Among other indications, her daughter clearly didn't feel like a girl, clearly wanted a boy's body, and was deeply distressed by these feelings. But Heather questioned whether these criteria, or much of the information she found online, told the whole story. "Psychologists know that adolescence is

fraught with uncertainty and identity searching, and this isn't even acknowledged," she told me.

Heather said most of the resources she found for parents of a gender-dysphoric child told her that if her daughter said she was trans, she was trans. If her daughter said she needed hormones, Heather's responsibility was to help her get on hormones. The most important thing she could do was *affirm* her daughter, which Heather and Mike interpreted as meaning they should agree with her declarations that she was transgender. Even if they weren't so certain.

As Heather was searching for answers, Claire's belief that she should transition was growing stronger. For months, she had been insistent that she wanted both testosterone and "top surgery"—a double mastectomy. She repeatedly asked her parents to find her doctors who could get her started on a path to physical transition. Heather and Mike bought time by telling her they were looking but hadn't been able to find anyone yet. "We also took her kayaking, played more board games with her and watched more TV with her, and took other short family trips," Heather recalled. "We also took away her ability to search online but gave her Instagram as a consolation." They told her they realized that she was in pain, but they also felt, based on what they'd learned in their research, that it was possible her feelings about her gender would change over time. They asked her to start keeping a journal, hoping it would help her explore those feelings.

Claire humored her parents, even as her frustration with them mounted. Eventually, though, something shifted. In a journal entry Claire wrote last November, she traced her realization that she wasn't a boy to one key moment. Looking in the mirror at a time when she was trying to present in a very male way—at "my baggy, uncomfortable clothes; my damaged, short hair; and my depressed-looking face"—she found that "it didn't make me feel any better. I was still miserable, and I still hated myself." From there, her distress gradually began to lift. "It was kind of sudden when I thought: *You know, maybe this isn't the right answer—maybe it's something else*," Claire told me. "But it took a while to actually set in that yes, I was definitely a girl."

Claire believes that her feeling that she was a boy stemmed from rigid views of gender roles that she had internalized. "I think I really had it set in stone what a guy was supposed to be like and what a girl was supposed to be like. I thought that if you didn't follow the stereotypes of a girl, you were a guy, and if you didn't follow the stereotypes of a guy, you were a girl." She hadn't seen herself in the other girls in her middle-school class, who were breaking into cliques and growing more gossipy. As she got a bit older, she found girls who shared her interests, and started to feel at home in her body.

Heather thinks that if she and Mike had heeded the information they found online, Claire would have started a physical transition and regretted it later. These days, Claire is a generally happy teenager whose mental-health issues have improved markedly. She still admires people, like Miles McKenna, who benefited from transitioning. But she's come to realize that's just not who she happens to be.

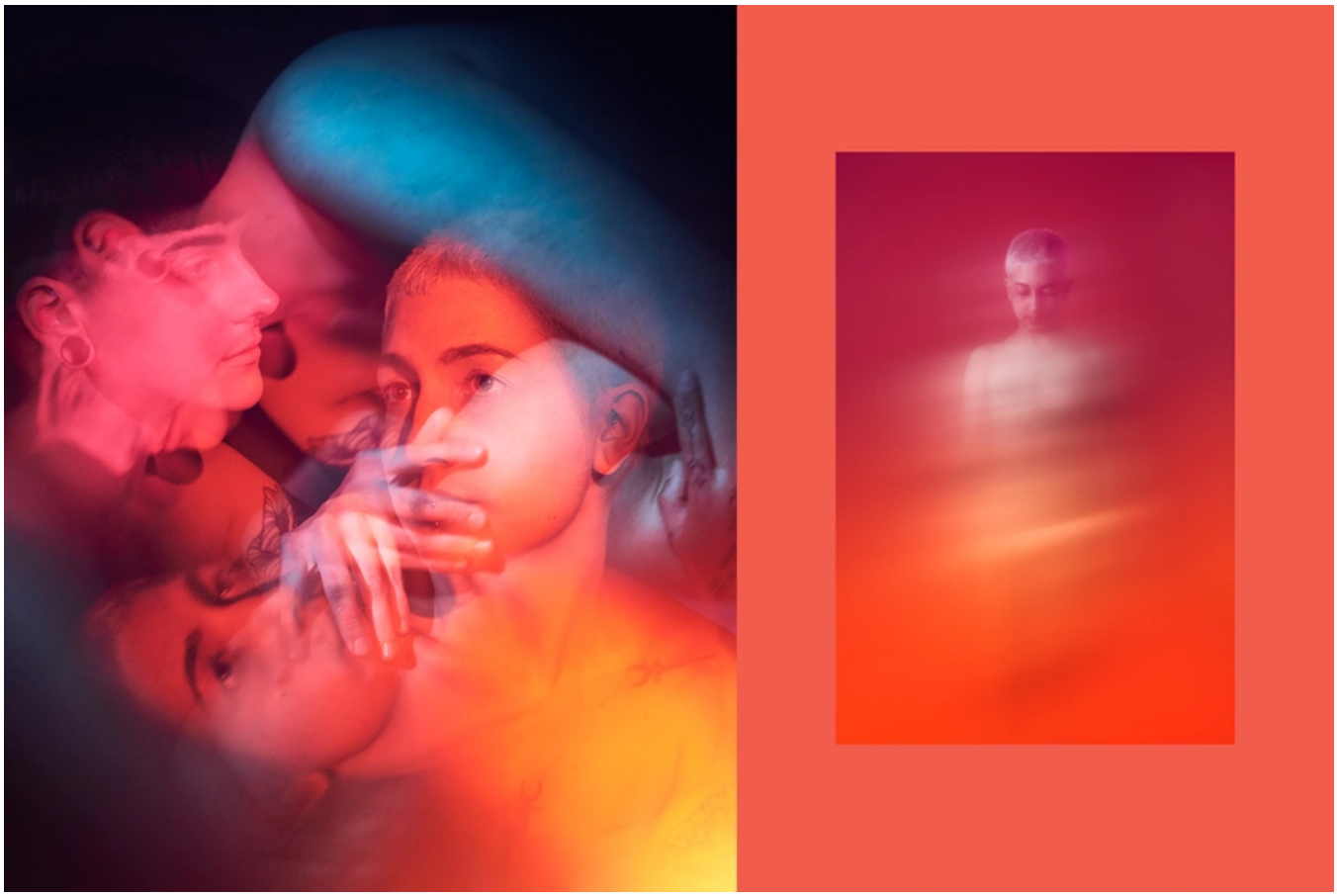
The number of self-identifying trans people in the United States is on the rise. In June 2016, the Williams Institute at the UCLA School of Law estimated that 1.4 million adults in the U.S. identify as transgender, a near-doubling of an estimate from about a decade earlier. As of 2017, according to the institute, about 150,000 teenagers ages 13 to 17 identified as trans. The number of young people seeking clinical services appears to be growing as well. A major clinic in the United Kingdom saw a more than 300 percent increase in new referrals over the past three years. In the U.S., where youth gender clinics are somewhat newer—40 or so are scattered across the country—solid numbers are harder to come by. Anecdotally, though, clinicians are reporting large upticks in new referrals, and waiting lists can stretch to five months or longer.

How can parents get children the support they might need while keeping in mind that adolescence is, by definition, a time of identity exploration?

The current era of gender-identity awareness has undoubtedly made life easier for many young people who feel constricted by the sometimes-oppressive nature

of gender expectations. A rich new language has taken root, granting kids who might have felt alone or excluded the words they need to describe their experiences. And the advent of the internet has allowed teenagers, even ones in parts of the country where acceptance of gender nonconformity continues to come far too slowly, to find others like them.

But when it comes to the question of physical interventions, this era has also brought fraught new challenges to many parents. Where is the line between not "feeling like" a girl because society makes it difficult to *be* a girl and needing hormones to alleviate dysphoria that otherwise won't go away? How can parents tell? How can they help their children gain access to the support and medical help they might need, while also keeping in mind that adolescence is, by definition, a time of fevered identity exploration?



Maciek Jasik

There is no shortage of information available for parents trying to navigate this difficult terrain. If you read the bible of medical and psychiatric care for transgender people—the *Standards of Care* issued by the World Professional Association for Transgender Health (WPATH)—you'll find an 11-page section

called "Assessment and Treatment of Children and Adolescents With Gender Dysphoria." It states that while some teenagers should go on hormones, that decision should be made with deliberation: "Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken." The American Psychological Association's guidelines sound a similar note, explaining the benefits of hormones but also noting that "adolescents can become intensely focused on their immediate desires." It goes on: "This intense focus on immediate needs may create challenges in assuring that adolescents are cognitively and emotionally able to make life-altering decisions."

The leading professional organizations offer this guidance. But some clinicians are moving toward a faster process. And other resources, including those produced by major LGBTQ organizations, place the emphasis on acceptance rather than inquiry. The Human Rights Campaign's "Transgender Children & Youth: Understanding the Basics" web page, for example, encourages parents to seek the guidance of a gender specialist. It also asserts that "being transgender is not a phase, and trying to dismiss it as such can be harmful during a time when your child most needs support and validation." Similarly, parents who consult the pages tagged "transgender youth" on GLAAD's site will find many articles about supporting young people who come out as trans but little about the complicated diagnostic and developmental questions faced by the parents of a gender-exploring child.

HRC, GLAAD, and like-minded advocacy groups emphasize the acceptance of trans kids for understandable reasons: For far too long, parents, as well as clinicians, denied the possibility that trans kids and teens even existed, let alone that they should be allowed to transition. Many such organizations are primarily concerned with raising awareness and correcting still-common misconceptions.

A similar motive seems to animate much of the media coverage of transgender young people. Two genres of coverage have emerged. Dating back at least to the 1993 murder of the Nebraska 21-year-old Brandon Teena, which inspired a documentary as well as the film *Boys Don't Cry*, a steady stream of horror stories has centered on bullying, physical assault, and suicide—real risks that transgender and gender-nonconforming (TGNC) young people still face.

More recently, a wave of success stories has appeared. In many of these accounts, kids are lost, confused, and frustrated right up until the moment they are allowed to grow their hair out and adopt a new name, at which point they finally become their true self. Take, for example, a Parents.com article in which a mother, writing pseudonymously, explains that she struggled with her child's gender-identity issues for years, until finally turning to a therapist, who, after a 20-minute evaluation, pronounced the child trans. Suddenly, everything clicked into place. The mother writes: "I looked at the child sitting between my husband and me, the child who was smiling, who appeared so happy, who looked as if someone finally saw him or her the way she or he saw him or herself." In a *National Geographic* special issue on gender, the writer Robin Marantz Henig recounts the story of a mother who let her 4-year-old, assigned male at birth, choose a girl's name, start using female pronouns, and attend preschool as a girl. "Almost instantly the gloom lifted," Henig writes.

For many young people in early studies, transitioning appears to have greatly alleviated their dysphoria. But it's not the answer for everyone.

Accounts of successful transitions can help families envision a happy outcome for a suffering child. And some young people clearly experience something like what these caterpillar-to-butterfly narratives depict. They have persistent, intense gender dysphoria from a very young age, and transitioning alleviates it. "Some kids don't waver" in their gender identity, Nate Sharon, a psychiatrist who oversaw a gender clinic in New Mexico for two and a half years, and who is himself trans, told me when we spoke in 2016. "I'm seeing an 11-year-old who at age 2 went up to his mom and said, 'When am I going to start growing my penis? Where's my penis?' At 2."

But these stories tend to elide the complexities of being a TGNC young person, or the parent of one. Some families will find a series of forking paths, and won't always know which direction is best. Like Claire's parents, they may be convinced that their child is in pain, but also concerned that physical transition is not the solution, at least not for a young person still in the throes of adolescence.

We are still in the earliest stages of understanding how physical transitioning affects dysphoric young people. While the specifics depend on your child's age, and can vary from case to case, the transition process for a persistently dysphoric child typically looks something like the following. First, allow your child to transition socially: to adopt the pronouns and style of dress of their authentic gender, and to change their name if they wish. As your child approaches adolescence, get them puberty-blocking drugs, because developing the secondary sex characteristics of their assigned sex could exacerbate their gender dysphoria. When they reach their teen years, help them gain access to the cross-sex hormones that will allow them to develop secondary sex characteristics in line with their gender identity. (Until recently, hormones were typically not prescribed until age 16; it's now more common for 15- and 14-year-olds, and sometimes even younger kids, to begin hormone therapy.)

In the United States, avoiding puberty became an option only a little more than a decade ago, so researchers have just begun tracking the kids engaged in this process, and we don't yet have comprehensive data about their long-term outcomes. Most of the data we do have involve kids who socially transitioned at an early age, but who hadn't yet physically transitioned. The information comes from a University of Washington researcher named Kristina Olson. Olson is the founder of the TransYouth Project, which is following a cohort of about 300 children for 20 years—the longest such longitudinal study based in the U.S. The kids she is tracking appear to be doing well—they don't seem all that different, in terms of their mental health and general happiness, from a control group of cisgender kids (that is, kids who identify with the sex they were assigned at birth).

At the prestigious Center of Expertise on Gender Dysphoria, at Vrije Universiteit University Medical Center, in Amsterdam—often referred to simply as "the Dutch clinic"—an older cohort of kids who went through the puberty-blockers-and-cross-sex-hormones protocol was also found to be doing well: "Gender dysphoria had resolved," according to a study of the group published in 2014 in *Pediatrics*. "Psychological functioning had steadily improved, and well-being was comparable to same-age peers."

These early results, while promising, can tell us only so much. Olson's findings come from a group of trans kids whose parents are relatively wealthy and are active in trans-support communities; they volunteered their children for the study. There are limits to how much we can extrapolate from the Dutch study as well: That group went through a comprehensive diagnostic process prior to transitioning, which included continuous access to mental-health care at a top-tier gender clinic—a process unfortunately not available to every young person who transitions.

Among the issues yet to be addressed by long-term studies are the effects of medications on young people. As Thomas Steensma, a psychologist and researcher at the Dutch clinic and a co-author of that study, explained to me, data about the potential risks of putting young people on puberty blockers are scarce. He would like to see further research into the possible effects of blockers on bone and brain development. (The potential long-term risks of cross-sex hormones aren't well known, but are likely modest, according to Joshua Safer, one of the authors of the Endocrine Society's "Clinical Practice Guideline" for treatment of gender dysphoria.)

Meanwhile, fundamental questions about gender dysphoria remain unanswered. Researchers still don't know what causes it—gender identity is generally viewed as a complicated weave of biological, psychological, and sociocultural factors. In some cases, gender dysphoria may interact with mental-health conditions such as depression and anxiety, but there's little agreement about how or why. Trauma, particularly sexual trauma, can contribute to or exacerbate dysphoria in some patients, but again, no one yet knows exactly why.

To reiterate: For many of the young people in the early studies, transitioning—socially for children, physically for adolescents and young adults—appears to have greatly alleviated their dysphoria. But it's not the answer for everyone. Some kids are dysphoric from a very young age, but in time become comfortable with their body. Some develop dysphoria around the same time they enter puberty, but their suffering is temporary. Others end up identifying as nonbinary—that is, neither male nor female.

Ignoring the diversity of these experiences and focusing only on those who were effectively "born in the wrong body" could cause harm. That is the argument of a small but vocal group of men and women who have transitioned, only to return to their assigned sex. Many of these so-called detransitioners argue that their dysphoria was caused not by a deep-seated mismatch between their gender identity and their body but rather by mental-health problems, trauma, societal misogyny, or some combination of these and other factors. They say they were nudged toward the physical interventions of hormones or surgery by peer pressure or by clinicians who overlooked other potential explanations for their distress.

Some of these interventions are irreversible. People respond differently to cross-sex hormones, but changes in vocal pitch, body hair, and other physical characteristics, such as the development of breast tissue, can become permanent. Kids who go on puberty blockers and then on cross-sex hormones may not be able to have biological children. Surgical interventions can sometimes be reversed with further surgeries, but often with disappointing results.

The concerns of the detransitioners are echoed by a number of clinicians who work in this field, most of whom are psychologists and psychiatrists. They very much support so-called affirming care, which entails accepting and exploring a child's statements about their gender identity in a compassionate manner. But they worry that, in an otherwise laudable effort to get TGNC young people the care they need, some members of their field are ignoring the complexity, and fluidity, of gender-identity development in young people. These colleagues are approving teenagers for hormone therapy, or even top surgery, without fully examining their mental health or the social and family influences that could be shaping their nascent sense of their gender identity.

That's too narrow a definition of affirming care, in the view of many leading clinicians. "Affirming care does not privilege any one outcome when it comes to gender identity, but instead aims to allow exploration of gender without judgment and with a clear understanding of the risks, benefits, and alternatives to any choice along the way," Aron Janssen, the clinical director of the Gender and Sexuality Service at Hassenfeld Children's Hospital, in New York, told me.

"Many people misinterpret affirming care as proceeding to social and medical transition in all cases without delay, but the reality is much more complex."

To make sense of this complex reality—and ensure the best outcome for all gender-exploring kids—parents need accurate, nuanced information about what gender dysphoria is and about the many blank spots in our current knowledge. They don't always get it.

For gender-dysphoric people, physical transition can be life enhancing, even lifesaving. While representative long-term data on the well-being of trans adults have yet to emerge, the evidence that does exist—as well as the sheer heft of personal accounts from trans people and from the clinicians who help them transition—is overwhelming. For many if not most unwaveringly gender-dysphoric people, hormones *work*. Surgery *works*. That's reflected in studies that consistently show low regret rates for the least-reversible physical procedures to address gender dysphoria. One 2012 review of past studies, for example, found that sex-reassignment surgery "is an effective treatment for [gender dysphoria] and the only treatment that has been evaluated empirically with large clinical case series." A study on "bottom surgery," or surgery designed to construct a penis or vagina, found that from 1972 to 2015, "only 0.6 percent of transwomen and 0.3 percent of transmen who underwent [these procedures] were identified as experiencing regret."

Those of us who have never suffered from gender dysphoria can have a hard time appreciating what's at stake. Rebecca Kling, an educator at the National Center for Transgender Equality, in Washington, D.C., told me that before she transitioned she felt as if she were constantly carrying around a backpack full of rocks. "That is going to make everything in my life harder, and in many cases is going to make things impossible," she said. "Of course being able to remove that heavy burden has added comfort and stability in my sense of myself and my body." Other trans people have offered similar descriptions of gender dysphoria—a weight, a buzzing, an unavoidable source of rumination and worry. Hormones and surgery grant transgender people profound relief.

Historically, they have been denied access to that relief. Christine Jorgensen, the first American to become widely known for transitioning through hormones and

surgery, in the 1950s, had to go to Denmark for her care. The trans historian Genny Beemyn notes that Jorgensen's doctor "received more than 1,100 letters from transsexual people, many of whom sought to be his patients," in the months after Jorgensen was treated. As a result of the requests, "the Danish government banned such procedures for non-citizens. In the United States, many physicians simply dismissed the rapidly growing number of individuals seeking gender-affirming surgeries as being mentally ill."

Today, the situation in the U.S. has improved, but the lack of access to transition services continues to be a problem. Whether trans people in this country can access treatments such as hormones and surgery depends on a variety of factors, ranging from where they live to what their health insurance will cover (if they have any) to their ability to navigate piles of paperwork. Erica Anderson, a trans woman and clinical psychologist who works at the Child and Adolescent Gender Center, at UC San Francisco's Benioff Children's Hospital, had no luck when she tried to get hormones from an endocrinologist in Philadelphia just a decade ago. "Even I, with my education and resources, was denied care and access," she told me. "The endocrinologist simply said, 'I don't do that.' I offered to provide her the guidelines from her own Endocrine Society," Anderson said. "She refused and wouldn't even look me in the eye. No referral or offer to help. She sent me away with nothing, feeling like I was an undesirable."

Many trans people have stories like Anderson's. For this reason, among others, trans communities can be skeptical of those who focus on negative transition outcomes. They have long dealt with "professionals who seem uncomfortable giving trans people the go-ahead to transition at all," Zinnia Jones, a trans woman who runs the website GenderAnalysis, told me in an email. They have also faced "unnecessarily protracted timelines for accessing care, a lack of understanding or excess skepticism of our identities from clinicians, and so on."

Groups like WPATH, the primary organization for psychologists, psychiatrists, endocrinologists, surgeons, and others who work with TGNC clients, have attempted to reverse this neglect in recent years. A growing number of adult gender clinics follow "informed consent" protocols, built on the philosophy that trans adults, once informed of the potential benefits and risks of medical procedures, have a right to make their own decisions about their body and

shouldn't have their need for services questioned by mental-health and medical professionals.

This shift is seen by many trans people and advocates as an important course correction after decades of gatekeeping—aloof professionals telling trans people they couldn't get hormones or surgery, because they weren't *really* trans, or hadn't been living as a trans person long enough, or were too mentally ill.

For gender-questioning children and teens, the landscape is different. A minor's legal guardian almost always has to provide consent prior to a medical procedure, whether it's a tonsillectomy or top surgery. WPATH and other organizations that provide guidance for transitioning young people call for thorough assessments of patients before they start taking blockers or hormones.

This caution comes from the concerns inherent in working with young people. Adolescents change significantly and rapidly; they may view themselves and their place in the world differently at 15 than they did at 12. "You've got the onset of puberty right around the age where they develop the concept of abstract thinking," said Nate Sharon, the New Mexico psychiatrist. "So they may start to conceptualize gender concepts in a much richer, broader manner than previously—and then maybe puberty blockers or cross-sex hormones aren't for them." That was true for Claire: A shift in her understanding of the nature of gender led her to realize that transitioning was not the answer for her.

For younger children, gender identity is an even trickier concept. In one experiment, for example, many 3-to-5-year-olds thought that if a boy put on a dress, he became a girl. Gender clinicians sometimes encounter young children who believe they are, or want to be, another gender because of their dress or play preferences—*I like rough-and-tumble play, so I must be a boy*—but who don't meet the criteria for gender dysphoria.

In the past, therapists and doctors interpreted the fluidity of gender identity among children as license to put gender-bending kids into the "right" box by encouraging—or forcing—them to play with the "right" toys and dress in the "right" clothes. Until about five years ago, according to one clinician's estimate, social transition was often frowned upon. For decades, trans-ness was sometimes tolerated in adults as a last-ditch outcome, but in young people it was more often

seen as something to be drummed out rather than explored or accepted. So-called reparative therapy has harmed and humiliated trans and gender-nonconforming children. In her book *Gender Born, Gender Made*, Diane Ehrensaft, the director of mental health at UC San Francisco's Child and Adolescent Gender Center, writes that victims of these practices "become listless or agitated, long for their taken-away favorite toys and clothes, and even literally go into hiding in closets to continue playing with the verboten toys or wearing the forbidden clothes." Such therapy is now viewed as unethical.

Affirming care is far more humane than older philosophies. But it conflicts, at least a little, with what we know about gender-identity fluidity in young people.

These days, mainstream youth-gender clinicians practice affirming care instead. They listen to their young patients, take their statements about their gender seriously, and often help facilitate social and physical transition. Affirming care has quickly become a professional imperative: Don't question who your clients are—let them tell you who they are, and accept their identity in a nurturing, encouraging manner.

The affirming approach is far more humane than older ones, but it conflicts, at least a little, with what we know about gender-identity fluidity in young people. What does it mean to be affirming while acknowledging that kids and teenagers can have an understanding of gender that changes over a short span? What does it mean to be affirming while acknowledging that feelings of gender dysphoria can be exacerbated by mental-health difficulties, trauma, or a combination of the two?

Clinicians are still wrestling with how to define affirming care, and how to balance affirmation and caution when treating adolescents. "I don't want to be a gatekeeper," Dianne Berg, a co-director of the National Center for Gender Spectrum Health, at the University of Minnesota, told me. "But I also worry that in opening the gates, we're going to have more adolescents that don't engage in the reflective work needed in order to make sound decisions, and there might

end up being more people when they are older that are like, *Oh, hmm—now I am not sure about this*."

When Max Robinson was 17, getting a double mastectomy made perfect sense to her. In fact, it felt like her only option—like a miraculous, lifesaving procedure. Though she had a woman's body, she was really a man. Surgery would finally offer her a chance to be herself.

I met Max, now 22, in an airy café in the quiet southern-Oregon town where she lives. She was wearing a T-shirt with a flannel button-down over it. On her head, a gray winter cap; at her feet, a shaggy white service dog. By the time we met, we'd spoken on the phone and exchanged a number of emails, and she had told me her story—one that suggests the complexity of gender-identity development.

Max recalled that as early as age 5, she didn't enjoy being treated like a girl. "I questioned my teachers about why I had to make an angel instead of a Santa for a Christmas craft, or why the girls' bathroom pass had ribbons instead of soccer balls, when I played soccer and knew lots of other girls in our class who loved soccer," she said.

She grew up a happy tomboy—until puberty. "People expect you to grow out of it" at that age, she explained, "and people start getting uncomfortable when you don't." Worse, "the way people treated me started getting increasingly sexualized." She remembered one boy who, when she was 12, kept asking her to pick up his pencil so he could look down her shirt.

"I started dissociating from my body a lot more when I started going through puberty," Max said. Her discomfort grew more internalized—less a frustration with how the world treated women and more a sense that the problem lay in her own body. She came to believe that being a woman was "something I had to control and fix." She had tried various ways of making her discomfort abate—in seventh grade, she vacillated between "dressing like a 12-year-old boy" and wearing revealing, low-cut outfits, attempts to defy and accede to the demands the world was making of her body. But nothing could banish her feeling that womanhood wasn't for her. She had more bad experiences with men, too: When she was 13, she had sex with an older man she was seeing; at the time, it felt consensual, but she has since realized that a 13-year-old can't consent to sex with

an 18-year-old. At 14, she witnessed a friend get molested by an adult man at a church slumber party. Around this time, Max was diagnosed with depression and generalized anxiety disorder.

In ninth grade, Max first encountered the concept of being transgender when she watched an episode of *The Tyra Banks Show* in which Buck Angel, a trans porn star, talked about his transition. It opened up a new world of online gender-identity exploration. She gradually decided that she needed to transition.

Max's parents were skeptical at first but eventually came around, signing her up for sessions with a therapist who specialized in gender-identity issues. She recalled that the specialist was very open to putting her on a track toward transition, though he suggested that her discomfort could have other sources as well. Max, however, was certain that transitioning was the answer. She told me that she "refused to talk about anything other than transition."

When Max was 16, her therapist wrote her a referral to see an endocrinologist who could help her begin the process of physical transition by prescribing male hormones. The endocrinologist was skeptical, Max said. "I think what she was seeing was a lesbian teenager," not a trans one. At the time, though, Max interpreted the doctor's reluctance as her "being ignorant, as her trying to hurt me." Armed with the referral from her therapist, Max got the endocrinologist to prescribe the treatment she sought.

Max started taking testosterone. She experienced some side effects—hot flashes, memory issues—but the hormones also provided real relief. Her plan all along had been to get top surgery, too, and the initially promising effects of the hormones helped persuade her to continue on this path. When she was 17, Max, who was still dealing with major mental-health issues, was scheduled for surgery.

Because Max had parental approval, the surgeon she saw agreed to operate on her despite the fact that she was still a minor. (It's become more common for surgeons to perform top surgeries on teenagers as young as 16 if they have parental approval. The medical norms are more conservative when it comes to bottom surgeries; WPATH says they should be performed only on adults who have been living in their gender role for at least one year.) Max went into the surgery

optimistic. “I was convinced it would solve a lot of my problems,” she said, “and I hadn’t accurately named a lot of those problems yet.”

Max Robinson went on cross-sex hormones when she was 16 and had a double mastectomy when she was 17. Now 22, she has detransitioned and identifies as a woman. (Chloe Aftel)

Max was initially happy with the results of her physical transformation. Before surgery, she wasn't able to fully pass as male. After surgery, between her newly masculinized chest and the facial hair she was able to grow thanks to the hormones, she felt like she had left behind the sex she had been assigned at birth. "It felt like an accomplishment to be seen the way I wanted to be seen," she told me.

But that feeling didn't last. After her surgery, Max moved from her native California to Portland and threw herself into the trans scene there. It wasn't a happy home. The clarity of identity she was seeking—and that she'd felt, temporarily, after starting hormones and undergoing surgery—never fully set in. Her discomfort didn't go away.

Today, Max identifies as a woman. She believes that she misinterpreted her sexual orientation, as well as the effects of the misogyny and trauma she had experienced as a young person, as being about gender identity. Because of the hormone therapy, she still has facial hair and is frequently mistaken for male as a result, but she has learned to live with this: "My sense of self isn't entirely dependent on how other people see me."

Max is one of what appears to be a growing number of people who believe they were failed by the therapists and physicians they went to for help with their gender dysphoria. While their individual stories differ, they tend to touch on similar themes. Most began transitioning during adolescence or early adulthood. Many were on hormones for extended periods of time, causing permanent changes to their voice, appearance, or both. Some, like Max, also had surgery.

Many detransitioners feel that during the process leading up to their transition, well-meaning clinicians left unexplored their overlapping mental-health troubles or past traumas. Though Max's therapist had tried to work on other issues with her, Max now believes she was encouraged to rush into physical transition by clinicians operating within a framework that saw it as the only way someone like her could experience relief. Despite the fact that she was a minor for much of the process, she says, her doctors more or less did as she told them.

"I'm a real-live 22-year-old woman with a scarred chest and a broken voice and a 5 o'clock shadow because I couldn't face the idea of growing up to be a woman," said Cari Stella, a detransitioner.

Over the past couple of years, the detransitioner movement has become more visible. Last fall, Max told her story to *The Economist*'s magazine of culture and ideas, *1843*. Detransitioners who previously blogged pseudonymously, largely on Tumblr, have begun writing under their real names, as well as speaking on camera in YouTube videos.

Cari Stella is the author of a blog called Guide on Raging Stars. Stella, now 24, socially transitioned at 15, started hormones at 17, got a double mastectomy at 20, and detransitioned at 22. "I'm a real-live 22-year-old woman with a scarred chest and a broken voice and a 5 o'clock shadow because I couldn't face the idea of growing up to be a woman," she said in a video posted in August 2016. "I was not a very emotionally stable teenager," she told me when we spoke. Transitioning offered a "level of control over how I was being perceived."

Carey Callahan is a 36-year-old woman living in Ohio who detransitioned after identifying as trans for four years and spending nine months on male hormones. She previously blogged under the pseudonym Maria Catt, but "came out" in a YouTube video in July 2016. She now serves as something of an older sister to a network of female, mostly younger detransitioners, about 70 of whom she has met in person; she told me she has corresponded online with an additional 300. (The detransitioners who have spoken out thus far are mostly people who were assigned female at birth. Traditionally, most new arrivals at youth gender clinics were assigned male; today, many clinics are reporting that new patients are mostly assigned female. There is no consensus explanation for the change.)

I met Carey in Columbus in March. She told me that her decision to detransition grew out of her experience working at a trans clinic in San Francisco in 2014 and 2015. "People had said often to me that when you transition, your gender dysphoria gets worse before it gets better," she told me. "But I saw and knew so many people who were cutting themselves, starving themselves, never

leaving their apartments. That made me doubt the narrative that if you make it all the way to medical transition, then it's probably going to work out well for you."

Carey Callahan serves as something of an older sister to a group of women who, like her, have detransitioned. (Matt Eich)

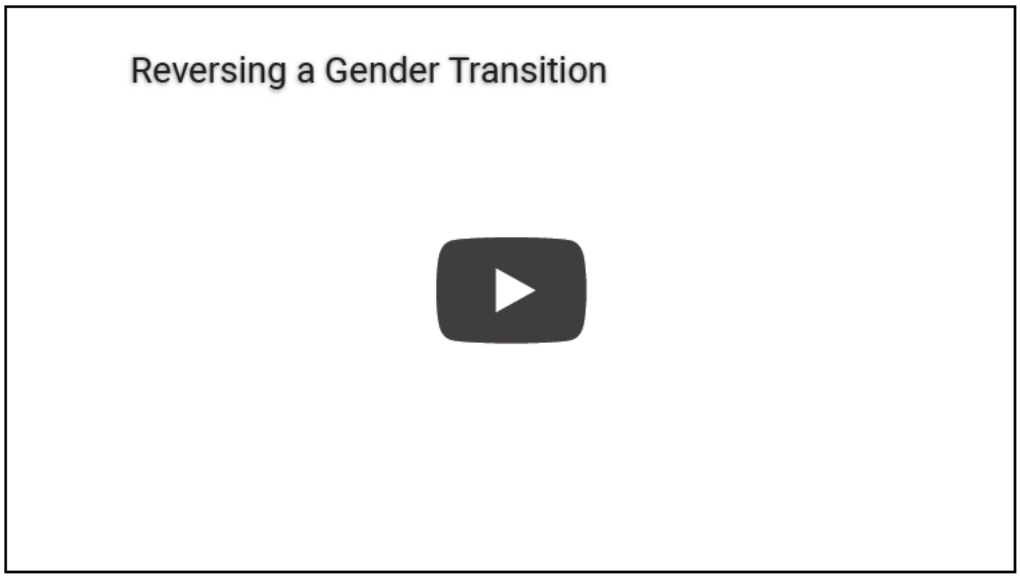
Carey said she met people who appeared to be grappling with severe trauma and mental illness, but were fixated on their next transition milestone, convinced *that* was the moment when they would get better. "I knew a lot of people committed to that narrative who didn't seem to be doing well," she recalled. Carey's time at the clinic made her realize that testosterone hadn't made *her* feel better in a sustained way either. She detransitioned, moved to Ohio, and is now calling for a more careful approach to treating gender dysphoria than what many detransitioners say they experienced themselves.

In part, that would mean clinicians adhering to guidelines like WPATH's *Standards of Care*, which are nonbinding. "When I look at what the *SOC* describes, and then I look at my own experience and my friends' experiences of pursuing hormones and surgery, there's hardly any overlap between the directives of the *SOC* and the reality of care patients get," Carey told me. "We didn't

discuss all the implications of medical intervention—psychological, social, physical, sexual, occupational, financial, and legal—which the *SOC* directs the mental-health professional to discuss. What the *SOC* describes and the care people get before getting cleared for hormones and surgery are miles apart."

Detransitioners, understandably, elicit suspicion from the trans community. Imagine being a trans person who endured a bruising fight to prove to your psychiatrist and endocrinologist that you are trans, in order to gain access to hormones that greatly improve your quality of life, that relieve suffering. You might view with skepticism—at the very least—a group calling for more gatekeeping. Conservative media outlets, for their part, often seize on detransition narratives to push the idea that being trans is some sort of liberal invention. "How Carey Was Set Free From Transgenderism" was the conservative website LifeSiteNews' disingenuous take on Carey's story.

Video: Reversing a Gender Transition



No one knows how common detransitioning is. A frequently cited statistic—that only 2.2 percent of people who physically transition later regret it—doesn't paint a complete picture. It comes from a study, conducted in Sweden, that examined only those people who had undergone sex-reassignment surgery and legally changed their gender, then applied to change their gender back—a standard that,

Carey pointed out, would have excluded her and most of the detransitioners she knows.

It stands to reason that as *any* medical procedure becomes more readily available, a higher number of people will regret having it. Why focus on detransitioners, when no one even knows whether their experiences are all that common? One answer is that clinicians who have logged thousands of hours working with transgender and gender-nonconforming young people are raising the same concerns.

When it comes to helping TGNC young people gain access to physical interventions, few American clinicians possess the bona fides of the psychologist Laura Edwards-Leeper. A decade ago, when she was working at Boston Children's Hospital, she visited the Dutch clinic to learn the puberty-blocking protocol pioneered there. She helped bring that protocol back to Boston, where she worked with the first-ever group of American kids to go through that process.

Today, Edwards-Leeper oversees a collaboration between Pacific University and Oregon's Transgender Clinic, within the nonprofit Legacy Health system. At Pacific, she is training clinical-psychology doctoral students to conduct "readiness assessments" for young people seeking physical-transition services.

In February, I visited one of her classes at Pacific, just outside Portland. For an hour, she let me pepper her students with questions about their experiences as clinicians-in-training in what is essentially a brand-new field. When the subject of detransitioners came up, Edwards-Leeper chimed in. "I've been predicting this for, I don't know, the last five or more years," she said. "I anticipate there being more and more and more, because there are so many youth who are now getting services with very limited mental-health assessment and sometimes no mental-health assessment. It's inevitable, I think."

Laura Edwards-Leeper, a clinician at Pacific University and Oregon's Transgender Clinic. She brought the puberty-blocking transition protocol pioneered by the Dutch to the U.S. (Matt Eich)

Edwards-Leeper believes that comprehensive assessments are crucial to achieving good outcomes for TGNC young people, especially those seeking physical interventions, in part because some kids who think they are trans at one point in time will not feel that way later on. This is a controversial subject in some corners of the trans community. A small group of studies has been interpreted as showing that the majority of children who experience gender dysphoria eventually stop experiencing it and come to identify as cisgender adults. (In these studies, children who suffer intense dysphoria over an extended period of time, especially into adolescence, are more likely to identify as trans in the long run.)

This so-called desistance research has been attacked on various methodological grounds. The most-credible critiques center on the claim that some kids who were merely gender *nonconforming*—that is, they preferred stereotypically cross-sex activities or styles of dress—but not *dysphoric* may have been counted as desisters because the studies relied on outdated diagnostic criteria, artificially

pushing the percentage upward. (The terms *detransition* and *desist* are used in different ways by different people. In this article, I am drawing this distinction: Detransitioners are people who undergo social or physical transitions and later reverse them; desisters are people who stop experiencing gender dysphoria without having fully transitioned socially or physically.)

The desistance rate for accurately diagnosed dysphoric kids is probably lower than some of the contested studies suggest; a small number of merely gender-nonconforming kids may indeed have been wrongly swept into even some of the most recent studies, which didn't use the most up-to-date criteria, from the *DSM-5*. And there remains a paucity of big, rigorous studies that might deliver a more reliable figure.

Within a subset of trans advocacy, however, desistance isn't viewed as a phenomenon we've yet to fully understand and quantify but rather as a myth to be dispelled. Those who raise the subject of desistance are often believed to have nefarious motives—the liberal outlet ThinkProgress, for example, referred to desistance research as "the pernicious junk science stalking trans kids," and a subgenre of articles and blog posts attempts to debunk "the desistance myth." But the evidence that desistance occurs is overwhelming. The American Psychological Association, the Substance Abuse and Mental Health Services Administration, the Endocrine Society, and WPATH all recognize that desistance occurs. I didn't speak with a single clinician who believes otherwise. "I've seen it clinically happen," Nate Sharon said. "It's not a myth."

Despite this general agreement, Edwards-Leeper worries that treatment practices are trending toward an interpretation of affirming care that entails nodding along with children and adolescents who say they want physical interventions rather than evaluating whether they are likely to benefit from them.

A decade ago, the opposite was true. "I was constantly having to justify why we should be offering puberty-blocking medication, why we should be supporting these trans youth to get the services they need," Edwards-Leeper recalled. "People thought this was just crazy, and thought the four-hour evaluations I was doing were, too—how could that possibly be enough to decide whether to go forward with the medical intervention? That was 2007, and now the questions I get are

'Why do you make people go through any kind of evaluation?' And 'Why does mental health need to be involved in this?' And 'We should just listen to what the kids say and listen to what the adolescents say and basically just treat them like adults.' "

The six trainees on Edwards-Leeper's Transgender Youth Assessment Team spoke about the myriad ways mental-health issues and social and cultural influences can complicate a child's conception of gender. "I would say 'affirming' isn't always doing exactly what the kid says they want in the moment," one said. Another added: "Our role as clinicians isn't to confirm or disconfirm someone's gender identity—it's to help them explore it with a little bit more nuance." I asked the students whether they had come across the idea that conducting in-depth assessments is insulting or stigmatizing. They all nodded. "Well, they know what reputation I have," Edwards-Leeper said with a laugh. "I told them about things almost being thrown at me at conferences."

"I think the pendulum has swung so far that now we're maybe not looking as critically at the issues as we should be," says the psychologist Dianne Berg.

Those conference troubles signaled to Edwards-Leeper that her field had shifted in ways she found discomfiting. At one conference a few years ago, she recalled, a co-panelist who was a well-respected clinician in her field said that Edwards-Leeper's comprehensive assessments required kids to "jump through more fiery hoops" and were "retraumatizing." This prompted a standing ovation from the audience, mostly families of TGNC young people. During another panel discussion, at the same conference with the same clinician, but this time geared toward fellow clinicians, the same thing happened: more claims that assessments were traumatizing, more raucous applause.

Edwards-Leeper isn't alone in worrying that the field is straying from its own established best practices. "Under the motivation to be supportive and to be affirming and to be nonstigmatizing, I think the pendulum has swung so far that now we're maybe not looking as critically at the issues as we should be," the

National Center for Gender Spectrum Health's Dianne Berg told me. Erica Anderson, the UCSF clinician, expressed similar concerns: "Some of the stories we've heard about detransitioning, I fear, are related to people who hastily embarked on medical interventions and decided that they weren't for them, and didn't thoroughly vet their decision either by themselves or with professional people who could help them."

Even some of the clinicians who have emphasized the need to be deferential to young people acknowledge the complexities at play here. A psychologist with decades of experience working with TGNC young people, Diane Ehrensaft is perhaps the most frequently quoted youth-gender clinician in the country. She is tireless in her advocacy for trans kids. "It's the children who are now leading us," she told *The Washington Post* recently. She sees this as a positive development: "If you listen to the children, you will discover their gender," she wrote in one article. "It is not for us to tell, but for them to say."

But when I spoke with Ehrensaft at her home in Oakland, she described many situations involving physical interventions in which her work was far more complicated than simply affirming a client's self-diagnosis. "This is what I tell kids all the time, particularly teenagers," she said. "Often they're pushing for fast. I say, 'Look, I'm old, you're young. I go slow, you go fast. We're going to have to work that out.' " Sometimes, she said, she suspects that a kid who wants hormones *right now* is simply reciting something he found on the internet. "It just feels wooden, is the only thing I can say," she told me.

At the end of our interview, Ehrensaft showed me a slide from a talk she was preparing about what it means to be an affirming clinician: "REALITY: WE ARE NEITHER RUBBER STAMPERS NOR PUSHERS; WE ARE FACILITATORS." This isn't so far off from the definition of the clinician's role expressed by Edwards-Leeper's students.

Competent clinicians do occasionally challenge their clients' conception of their gender identity in order to ensure that they are approaching the subject in a sufficiently sophisticated manner. They want to make sure that a given patient has gender dysphoria, as defined in the *DSM-5*, and that their current gender identity is a consistent part of who they are. If a teenager finds

that his dysphoria lessens significantly when he presents himself in a more feminine way or once his overlapping mental-health problems have been treated, he may develop a different view on the necessity of hormones or surgery.

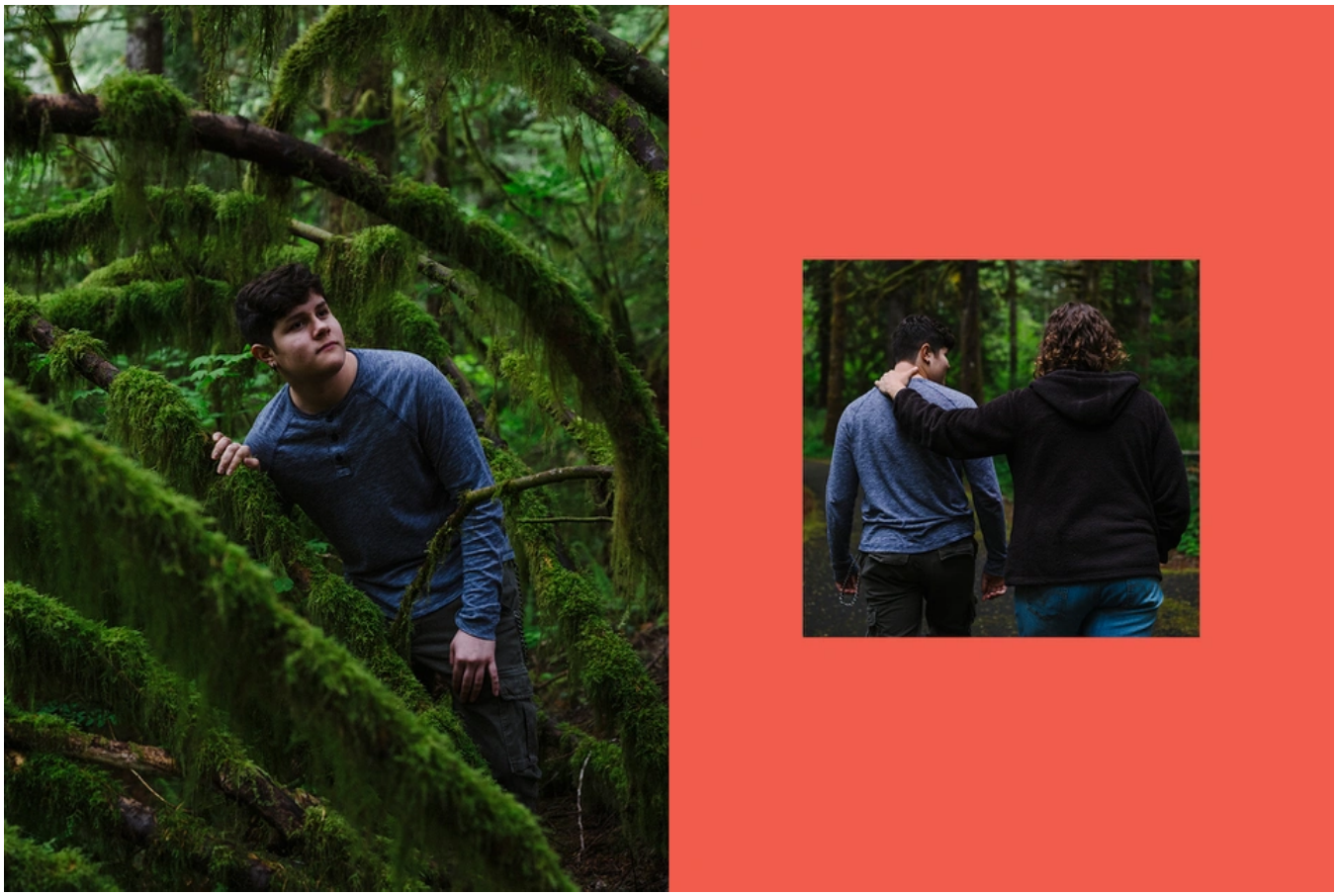
This is not to say that talk therapy can cure serious gender dysphoria. Edwards-Leeper worked to introduce the Dutch protocol of blockers and hormones in the United States precisely because she believes that it alleviates dysphoria in cases where there would otherwise be prolonged suffering. But clinicians like her are also careful, given the upheavals of adolescence and the fluid conception of gender identity among young people, not to assume that because a young person has gender dysphoria, they should automatically go on hormones.

Edwards-Leeper is hoping to promote a concept of affirming care that takes into account the developmental nuances that so often come up in her clinical work. In this effort, she is joined by Scott Leibowitz, a psychiatrist who treats children and adolescents. He is the medical director of behavioral health for the THRIVE program at Nationwide Children's Hospital, in Columbus. Leibowitz has a long history of working with and supporting TGNC youth—he served as an expert witness for the Department of Justice in 2016, when President Barack Obama's administration challenged state-level "bathroom bills" that sought to prevent trans people from using the public bathroom associated with their gender identity. Edwards-Leeper and Leibowitz met at Boston Children's, where Leibowitz did his psychiatry fellowship, and the two have been close friends and collaborators ever since.

While it's understandable, for historical reasons, why some people associate comprehensive psychological assessments with denial of access to care, that isn't how Leibowitz and Edwards-Leeper view their approach. Yes, they want to discern whether a patient actually has gender dysphoria. But comprehensive assessments and ongoing mental-health work are also means of ensuring that transitioning—which can be a physically and emotionally taxing process for adolescents even under the best of circumstances—goes smoothly.

Scott Padberg, one of Edwards-Leeper's patients, is a good example of how her comprehensive-assessment process looks for teenagers with a relatively straightforward history of persistent gender dysphoria and an absence of other

factors that might complicate their diagnosis and transition path. I met Scott and his grandmother and legal guardian, Nancy, at a wrap place in Welches, Oregon, not far from where they live. It was a mild February day, so we sat in one of the pine booths outside the restaurant. Mount Hood's massive snowcapped peak loomed nearby.



Scott Padberg, a 16-year-old patient of Laura Edwards-Leeper who went on cross-sex hormones and recently had a double mastectomy (Matt Eich)

Scott, a 16-year-old who radiates calm, explained that despite having been assigned female at birth, he simply never felt like a girl. "I guess I kinda felt different since I felt conscious of the fact that I was alive," he said. For part of his childhood, that was fine with everyone around him. He was granted all the freedom he needed to express himself in a gender-nonconforming manner, from getting short haircuts to playing with stereotypically male toys like dinosaurs and Transformers. But the freedom didn't last. When he was 7, his mom married a "super Christian guy" who tried to impose femininity on him. "It's really degrading," Scott said, to be forced to wear a dress when you're a trans boy. (Scott's mom divorced her devout husband two years later, and Nancy eventually took custody of Scott.)

Puberty brought bigger problems. Scott started developing breasts and got his period. "Everything just sucked, basically," he said. "I was pretty miserable with it." In 2015, when Scott was 13, Nancy took him to an assessment appointment with Edwards-Leeper. "She asked me about how I felt when I was younger—was I comfortable with my body? What did I tend to like or be interested in?," Scott recalled. He said that getting on testosterone took what felt like a long time. (He was on puberty blockers for about a year.) But he said he understood that Edwards-Leeper was making certain he had considered a range of questions—from how he would feel about possibly not being able to have biological kids to whether he was comfortable with certain hormonal effects, such as a deeper voice. Scott told Edwards-Leeper that he was pretty certain about what he wanted.

Scott told me that overall, being on testosterone made him feel better, though also a bit more into "adrenaline-junkie stuff" than before. (There had been a recent incident involving Scott taking Nancy's car for a spin despite not yet having his learner's permit.) When I asked him about top surgery, which he was hoping to have early in the spring, he got about as animated as I saw him during our lunch. "Oh, it's going to be so freeing," he said. "I can change in the locker room!" In April I checked in with Nancy, and she said in an email that the surgery had gone well: "He is SO happy not to have to wear a binder!"

Scott's assessment process centered mostly on the basic readiness questions Edwards-Leeper and Leibowitz are convinced should be asked of any young person considering hormones. But his was a relatively clear-cut case: He'd had unwavering gender dysphoria since early childhood, a lack of serious mental-health concerns, and a generally supportive family. For other gender-dysphoric young people, mental-health problems and family dynamics can complicate the transition process, though they are by no means, on their own, an indication that someone shouldn't transition.

I met Orion Foss at a vegetarian café in the Dennison Place neighborhood of Columbus. Orion is an expressive 18-year-old with big eyes who is where Scott Padberg may be in a couple of years. Orion's gender trajectory was a bit different, though. As a teenager, he identified as a lesbian and became involved in the local LGBTQ scene. He says that in 2014, when he was 14 years old and trans

narratives were starting to show up more frequently on social media, he realized he was trans. He was also suffering from severe depression and anxiety at the time, which had led to self-harm issues, as well as what may have been an undiagnosed eating disorder. Orion believed that additional weight went straight to his hips and chest, accentuating his feminine features. At one point, he dipped down to 70 pounds.

A year or so after he realized he was trans, he told his mother, an ob-gyn, who took him to the THRIVE program at Nationwide, which had recently opened. (Leibowitz didn't work there yet.) Orion met with two clinicians for an eight-hour assessment. He told me he was "definitely intimidated," but if "you want to do something permanent to your body, you have to be absolutely positive that there's no other way of doing it."

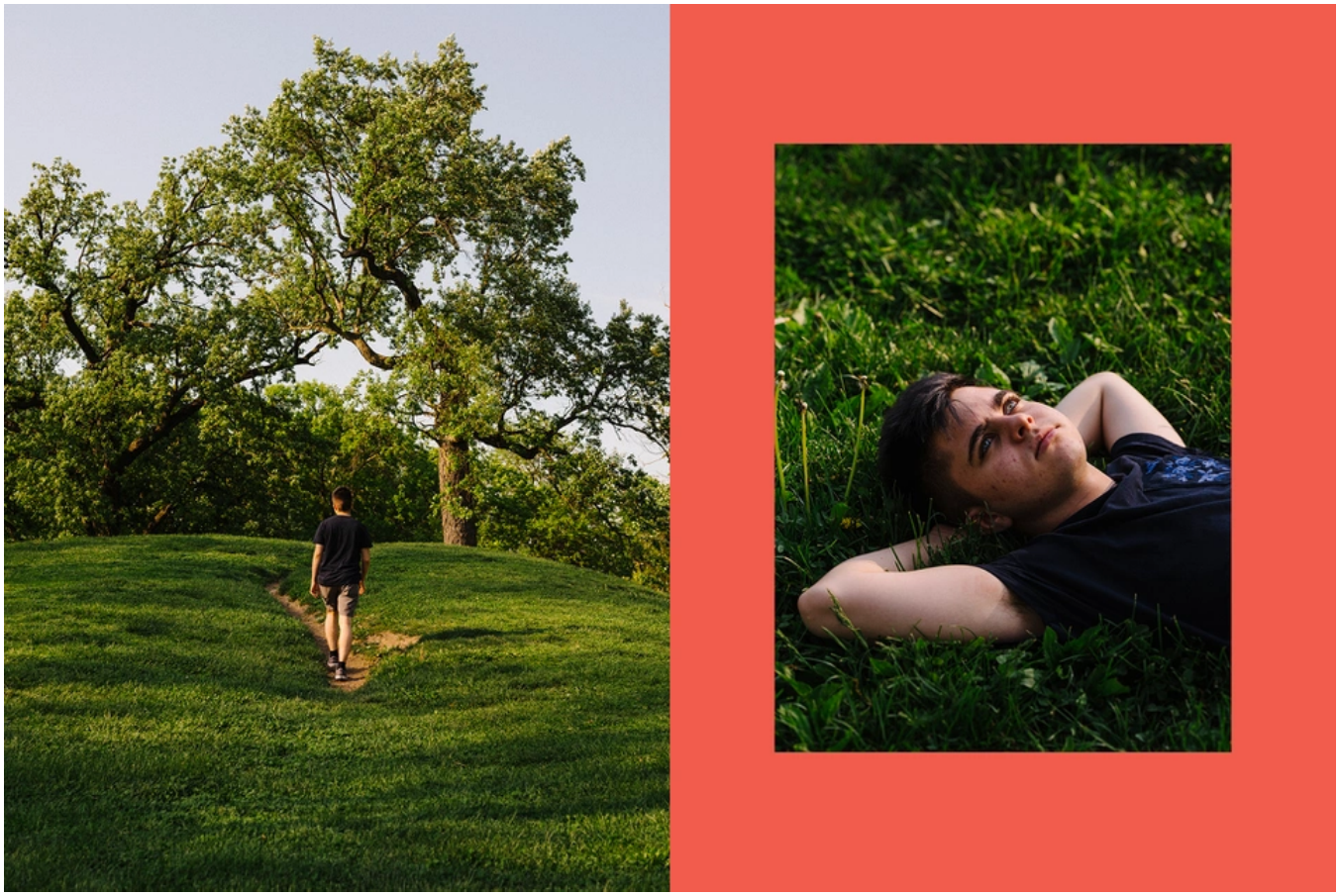
At the time, Orion was initially upset that, because he was underage, THRIVE wouldn't put him on hormones without the consent of both parents (his father had signed off, but his mother had not). He started sobbing when he found out. But the THRIVE team made clear that it was going to help him get where he wanted to be. In the meantime, a THRIVE therapist, Lourdes Hill, would work with Orion to address his anxiety and depression.

Looking back, Orion sees the value of this process. "If I had been put on hormone therapy when I didn't have my identity settled, and who I was settled, and my emotions settled, it would have been crazy. 'Cause when I did start hormone therapy, hormones shoot your mood all around, and it's not exactly safe to just shoot hormones into someone that's not stable." He ended up seeing Hill for weekly appointments, talking about not only his gender-identity and mental-health issues, but a host of other subjects as well. "She weeded through every possible issue with me that she could get to," he said. "I'm glad she made me wait. And I'm glad the structure was there so I couldn't just throw myself into something that probably would have made me worse off."

Eventually, his mother, who was "very hesitant," and was refusing to sign the paperwork for him to start hormones, came around. The THRIVE team helped her come to grips with the fact that the child she had always known as her daughter was going to become her son. "Lourdes was the driving force in that,"

Orion told me in a follow-up email. "Spent a lot of time with me and my mother in therapy."

When he was finally able to begin the hormone treatments, Orion said, he "immediately felt this weight off my shoulders." His dosage was gradually increased and then, in May 2017, he got a double mastectomy. Orion's transition has clearly had a profoundly beneficial effect. It's changed the way he carries himself in the world. Before, "I would sit like this"—he slouched over—"and hide every possible female thing about me." Now, he said, he can sit up straight. He feels like himself.



Orion Foss worked with the clinicians at Ohio's THRIVE clinic on his mental health, his mother's concerns, and, eventually, his transition. (Matt Eich)

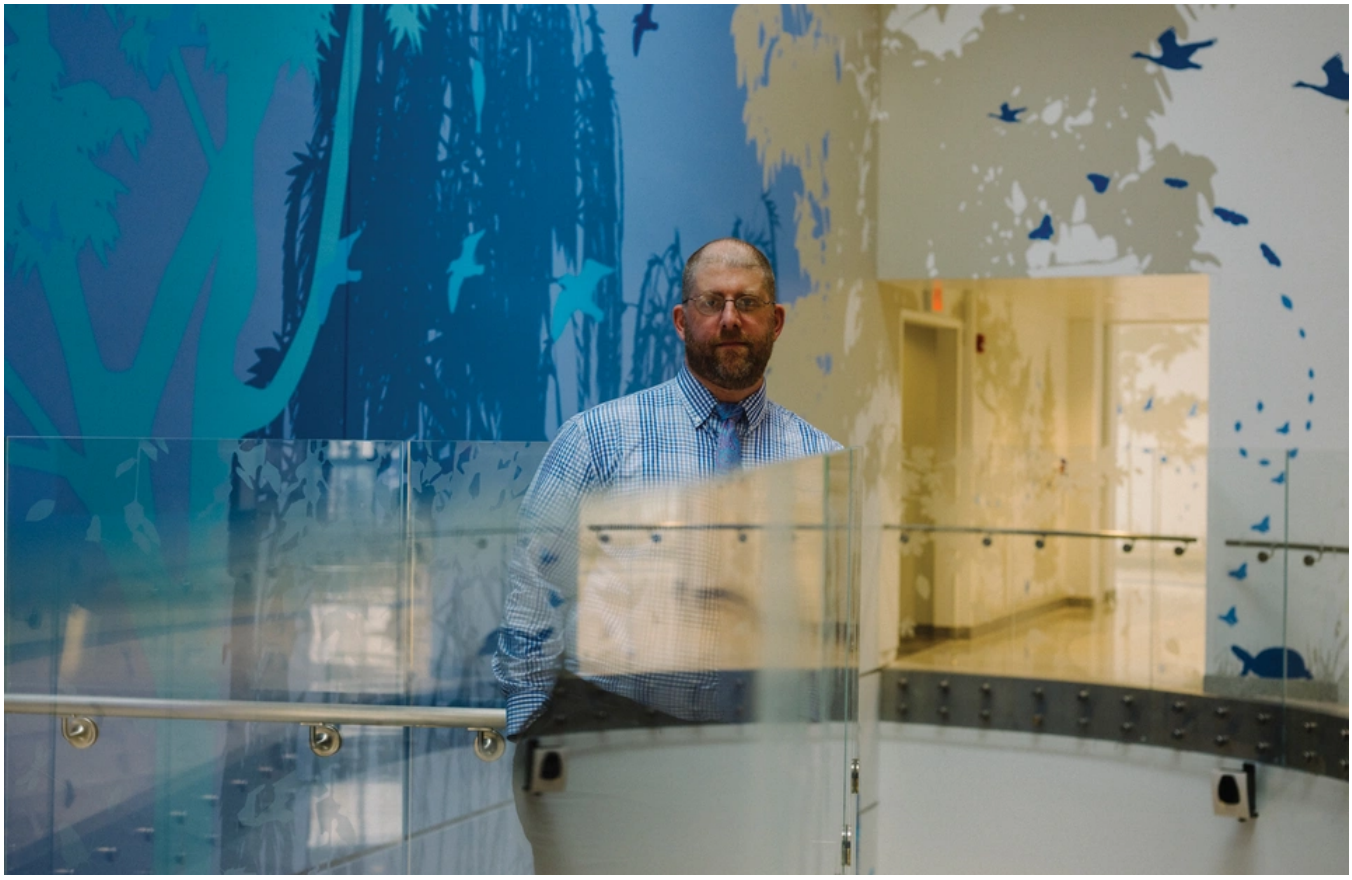
Some parents struggle with the challenges of raising a TGNC child, and they can make gender clinicians' already complicated jobs that much more complicated. Many, like Orion Foss's mother, have trouble accepting the idea of their child transitioning. She, at least, came around. In other cases, parents not only refuse to help their child receive treatment but physically abuse them or kick them out of the house. (Reliable numbers for trans young people

specifically are hard to come by, but LGBTQ youth are 120 percent more likely than their straight or cisgender counterparts to experience a period of homelessness, according to a study by Chapin Hall, a research center at the University of Chicago.)

But progressive-minded parents can sometimes be a problem for their kids as well. Several of the clinicians I spoke with, including Nate Sharon, Laura Edwards-Leeper, and Scott Leibowitz, recounted new patients' arriving at their clinics, their parents having already developed detailed plans for them to transition. "I've actually had patients with parents pressuring me to recommend their kids start hormones," Sharon said.

In these cases, the child might be capably navigating a liminal period of gender exploration; it's the parents who are having trouble not knowing whether their kid is a boy or a girl. As Sharon put it: "Everything's going great, but Mom's like, 'My transgender kid is going to commit suicide as soon as he starts puberty, and we need to start the hormones now.' And I'm like, 'Actually, your kid's just fine right now. And we want to leave it open to him, for him to decide that.' Don't put that in stone for this kid, you know?"

Suicide is the dark undercurrent of many discussions among parents of TGNC young people. Suicide and suicidal ideation are tragically common in the transgender community. An analysis conducted by the American Foundation for Suicide Prevention and the Williams Institute, published in 2014, found that 41 percent of trans respondents had attempted suicide; 4.6 percent of the overall U.S. population report having attempted suicide at least once. While the authors note that for methodological reasons 41 percent is likely an overestimate, it still points to a scarily high figure, and other research has consistently shown that trans people have elevated rates of suicidal ideation and suicide relative to cisgender people.



Scott Leibowitz, a psychiatrist who treats children and adolescents in Columbus, Ohio, is a proponent of comprehensive assessments for young people seeking to transition. (Matt Eich)

But the existence of a high suicide rate among trans people—a population facing high instances of homelessness, sexual assault, and discrimination—does not imply that it is common for young people to become suicidal if they aren't granted immediate access to puberty blockers or hormones. Parents and clinicians do need to make fraught decisions fairly quickly in certain situations. When severely dysphoric kids are approaching puberty, for instance, blockers can be a crucial tool to buy time, and sometimes there's a genuine rush to gain access to them, particularly in light of the waiting lists at many gender clinics. But the clinicians I interviewed said they rarely encounter situations in which immediate access to hormones is the difference between suicide and survival. Leibowitz noted that a relationship with a caring therapist may itself be an important prophylactic against suicidal ideation for TGNC youth: "Often for the first time having a medical or mental-health professional tell them that they are going to take them seriously and really listen to them and hear their story often helps them feel better than they've ever felt."

The conversations parents are having about gender-dysphoric children online aren't always so nuanced, however. In many of these conversations, parents who say they have questions about the pace of their child's transition, or whether gender dysphoria is permanent, are told they are playing games with their child's life. "Would you rather have a live daughter or a dead son?" is a common response to such questions. "This type of narrative takes an already fearful parent and makes them even more afraid, which is hardly the type of mind-set one would want a parent to be in when making a complex lifelong decision for their adolescent," Leibowitz said.

When parents discuss the reasons they question their children's desire to transition, whether in online forums or in response to a journalist's questions, many mention "social contagion." These parents are worried that their kids are influenced by the gender-identity exploration they're seeing online and perhaps at school or in other social settings, rather than experiencing gender dysphoria.

In some cases, a child might be capably navigating a liminal period of gender exploration; it's the parents who are having trouble not knowing whether their kid is a boy or a girl.

Many trans advocates find the idea of social contagion silly or even offensive given the bullying, violence, and other abuse this population faces. They also point out that some parents simply might not *want* a trans kid—again, parental skepticism or rejection is a painfully common experience for trans young people. Michelle Forcier, a pediatrician who specializes in youth-gender issues in Rhode Island, said the trans adolescents she works with frequently tell her things like *No one's taking me seriously—my parents think this is a phase or a fad*.

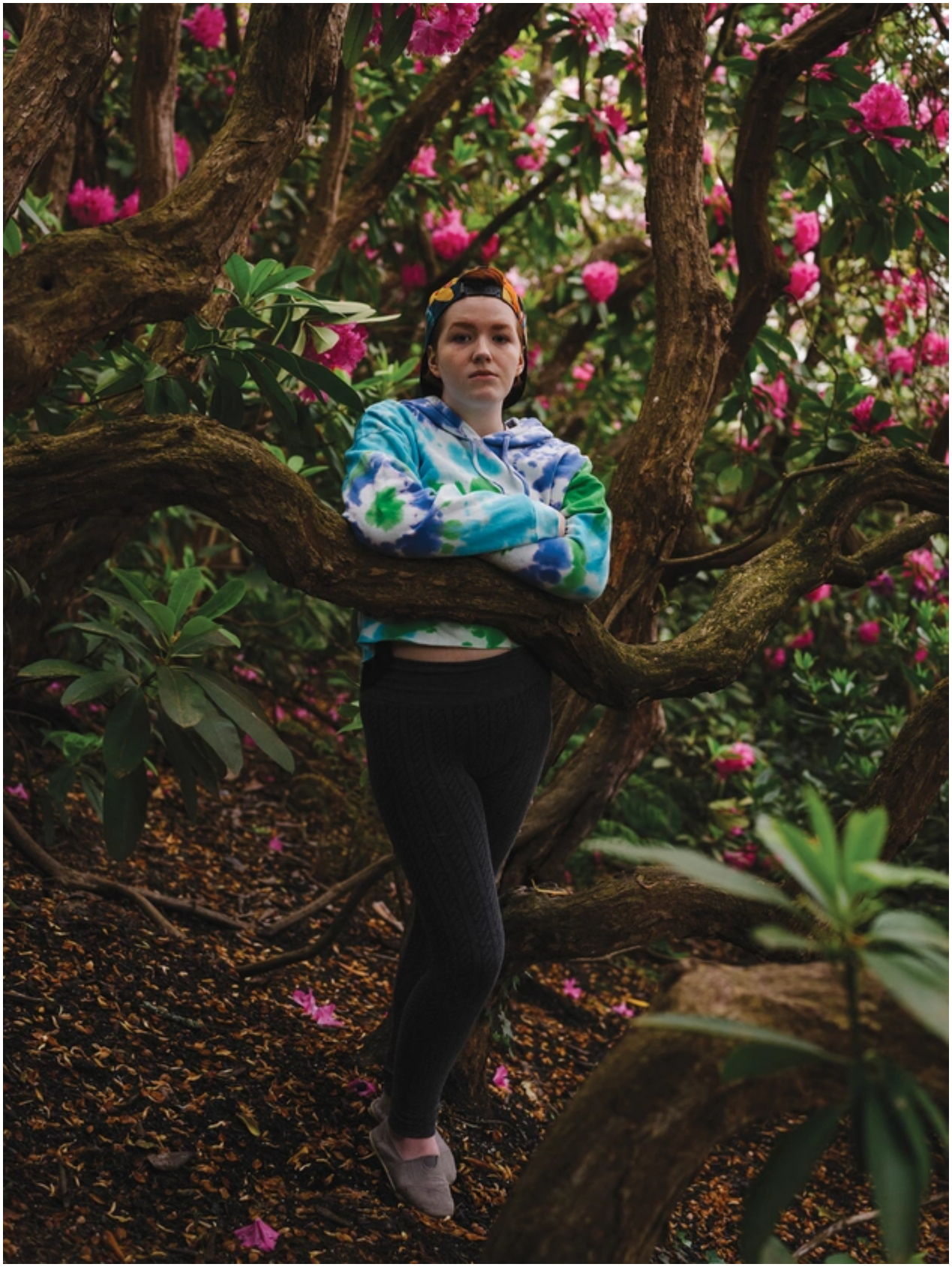
But some anecdotal evidence suggests that social forces *can* play a role in a young person's gender questioning. "I've been seeing this more frequently," Laura Edwards-Leeper wrote in an email. Her young clients talk openly about peer influence, saying things like *Oh, Steve is really trans, but Rachel is just doing it for attention*. Scott Padberg did exactly this when we met for lunch: He said there

are kids in his school who claim to be trans but who he believes are not. "They all flaunt it around, like: 'I'm trans, I'm trans, I'm trans,' " he said. "They post it on social media."

I heard a similar story from a quirky 16-year-old theater kid who was going by the nickname Delta when we spoke. She lives outside Portland, Oregon, with her mother and father. A wave of gender-identity experimentation hit her social circle in 2013. Suddenly, it seemed, no one was cisgender anymore. Delta, who was 13 and homeschooled, soon announced to her parents that she was genderqueer, then nonbinary, and finally trans. Then she told them she wanted to go on testosterone. Her parents were skeptical, both because of the social influence they saw at work and because Delta had anxiety and depression, which they felt could be contributing to her distress. But when her mother, Jenny, sought out information, she found herself in online parenting groups where she was told that if she dragged her feet about Delta's transition, she was potentially endangering her daughter. "Any questioning brought down the hammer on you," she told me.

Delta's parents took her to see Edwards-Leeper. The psychologist didn't question her about being trans or close the door on her *eventually* starting hormones. Rather, she asked Delta a host of detailed questions about her life and mental health and family. Edwards-Leeper advised her to wait until she was a bit older to take steps toward a physical transition—as Delta recalled, she said something like "I acknowledge that you feel a certain way, but I think we should work on other stuff first, and then if you still feel this way later on in life, then I will help you with that."

"Other stuff" mostly meant her problems with anxiety and depression. Edwards-Leeper told Jenny and Delta that while Delta met the clinical threshold for gender dysphoria, a deliberate approach made the most sense in light of her mental-health issues.



Delta, a patient of Laura Edwards-Leeper who wanted to transition. Edwards-Leeper counseled her to take things slowly and to work on her co-occurring mental-health issues. Her gender dysphoria eventually lifted. (Matt Eich)

"At the time I was not happy that she told me that I should go and deal with mental stuff first," Delta said, "but I'm glad that she said that, because too many

people are so gung ho and just like, 'You're trans, just go ahead,' even if they aren't—and then they end up making mistakes that they can't redo." Delta's gender dysphoria subsequently dissipated, though it's unclear why. She started taking antidepressants in December, which seem to be working. I asked Delta whether she thought her mental-health problems and identity questioning were linked. "They definitely were," she said. "Because once I actually started working on things, I got better and I didn't want anything to do with gender labels—I was fine with just being me and not being a specific thing."

It's imperative to remember that Delta's is a kind of story that can happen only in a place where trans people are accepted—and where parents, even skeptical ones like Jenny, are open-minded enough to take their kid to a clinician like Edwards-Leeper. In vast swaths of the United States, kids coming out as trans are much more likely to be met with hostility than with enhanced social status or recognition, and their parents are more likely to lack the willingness—or the resources—to find them care. But to deny the possibility of a connection between social influences and gender-identity exploration among adolescents would require ignoring a lot of what we know about the developing teenage brain—which is more susceptible to peer influence, more impulsive, and less adept at weighing long-term outcomes and consequences than fully developed adult brains—as well as individual stories like Delta's.

Not everyone agrees about the importance of comprehensive assessments for transgender and gender-nonconforming youth. Within the small community of clinicians who work with TGNC young people, some have a reputation for being skeptical about the value of assessments. Johanna Olson-Kennedy, a physician who specializes in pediatric and adolescent medicine at Children's Hospital Los Angeles and who is the medical director of the Center for Transyouth Health and Development, is one of the most sought-out voices on these issues, and has significant differences with Edwards-Leeper and Leibowitz. In "Mental Health Disparities Among Transgender Youth: Rethinking the Role of Professionals," a 2016 *JAMA Pediatrics* article, she wrote that "establishing a therapeutic relationship entails honesty and a sense of safety that can be compromised if young people believe that what they need and deserve

(potentially blockers, hormones, or surgery) can be denied them according to the information they provide to the therapist."

One clinician said her trans clients talk openly about peer influence, saying things like Oh, Steve is really trans, but Rachel is just doing it for attention.

This view is informed by the fact that Olson-Kennedy is not convinced that mental-health assessments lead to better outcomes. "We don't actually have data on whether psychological assessments lower regret rates," she told me. She believes that therapy can be helpful for many TGNC young people, but she opposes mandating mental-health assessments for all kids seeking to transition. As she put it when we talked, "I don't send someone to a therapist when I'm going to start them on insulin." Of course, gender dysphoria is listed in the *DSM-5*; juvenile diabetes is not.

One recent study co-authored by Olson-Kennedy, published in the *Journal of Adolescent Health*, showed that her clinic is giving cross-sex hormones to kids as young as 12. This presses against the boundaries of the Endocrine Society's guidelines, which state that while "there may be compelling reasons to initiate sex hormone treatment prior to age 16 years … there is minimal published experience treating prior to 13.5 to 14 years of age."

If you see gender-dysphoric 13- and 14-year-olds not as young people with a condition that may or may not indicate a permanent identity, but as *trans kids*, full stop, it makes sense to want to grant them access to transition resources as quickly as possible. Olson-Kennedy said that the majority of the patients she sees do need that access. She said she sees a small number of patients who desist or later regret transitioning; those patients, in her opinion, shouldn't dictate the care of others. She would like to see a radical reshaping of care for TGNC young people. "The way that the care has been organized is around assuring the certainty and decreasing the discomfort of the professionals (usually cisgender) who determine if the young people are ready or not," she told me. "And that's a broken model."

How best to support TGNC kids is a whiplash-inducing subject. To understand even just the small set of stories I encountered in my reporting—stories involving relatively privileged white kids with caring, involved families, none of which is necessarily the case for all TGNC young people in the United States—requires keeping several seemingly conflicting claims in mind. Some teenagers, in the years ahead, are going to rush into physically transitioning and may regret it. Other teens will be prevented from accessing hormones and will suffer great anguish as a result. Along the way, a heartbreaking number of trans and gender-nonconforming teens will be bullied and ostracized and will even end their own lives.

Some LGBTQ advocates have called for gender dysphoria to be removed from the *DSM-5*, arguing that its inclusion pathologizes being trans. But gender dysphoria, as science currently understands it, is a painful condition that requires treatment to be alleviated. Given the diversity of outcomes among kids who experience dysphoria at one time or another, it's hard to imagine a system without a standardized, comprehensive diagnostic protocol, one designed to maximize good outcomes.

Experiencing gender dysphoria isn't the same as experiencing anxiety or depression or psychological ailments, of course. But in certain ways it is similar: As with other psychiatric conditions, some people experience dysphoria more acutely than others; its severity can wax and wane within an individual based on a variety of factors; it is in many cases intimately tied to an individual's social and familial life. For some people, it will pass; for others, it can be resolved without medical interventions; for still others, only the most thorough treatment available will relieve immense suffering. We recognize that there is no one-size-fits-all approach to treating anxiety or depression, and a strong case can be made that the same logic should prevail with gender dysphoria.

Perhaps a first step is to recognize detransitioners and desisters as being on the same "side" as happily transitioned trans people. Members of each of these groups have experienced gender dysphoria at some point, and all have a right to compassionate, comprehensive care, whether or not that includes hormones or surgery. "The detransitioner is probably just as scarred by the system as the transitioner who didn't have access to transition," Leibowitz told me. The best

way to build a system that fails fewer people is to acknowledge the staggering complexity of gender dysphoria—and to acknowledge just how early we are in the process of understanding it.

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